

ACCOUNTABLE CARE ORGANIZATION PAYMENT SYSTEMS

payment**basics**

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Accountable care organizations (ACOs) are groups of health care providers that have agreed to be held accountable for the cost and quality of care for a group of beneficiaries. ACOs may qualify for shared savings payments if the spending for their assigned patients is lower than expected and may be required to make payments to CMS if the spending is higher than expected. The goals for ACOs are to improve coordination and quality of care, maintain beneficiary choice of provider, and reduce unnecessary service use. Beneficiaries do not enroll in ACOs; instead, Medicare assigns beneficiaries to ACOs based on their Medicare claims history.¹ The beneficiary is still free to use providers outside of the ACO. If assigned beneficiaries choose to go to a provider outside of the ACO, the ACO remains responsible for that spending. This creates an incentive for the ACO providers to satisfy their patients and keep them in the ACO. Medicare provides ACOs with claims data for assigned beneficiaries to help the ACOs coordinate care. This design avoids some of the overhead costs associated with Medicare Advantage (MA) plans, such as marketing, enrollment, creating networks, and paying claims.

There are currently three major Medicare ACO programs. The Medicare Shared Savings Program (MSSP) is a permanent part of the Medicare program. It was created by the Patient Protection and Affordable Care Act of 2010 (PPACA) and became operational in 2012. The program has 506 ACOs serving 10.5 million beneficiaries. The MSSP has three separate tracks with varying risk arrangements and other parameters. Track 1 and Track 2 have been in effect since the program started in 2012. Track 3 began in 2016. Track 1 contains bonuses only (one-sided risk). Tracks 2 and 3 incorporate bonuses and downside risk (two-sided risk).

The second ACO program is the Next Generation ACO demonstration, which started in 2016 and now has 51 ACOs

participating. It incorporates higher levels of risk and reward than the MSSP and also includes a small financial incentive for beneficiaries to use ACO providers. Spending targets are set differently so that they are more predictable and require the ACO to achieve a certain level of efficiency before qualifying for shared savings payments.

The third ACO program is the Medicare ACO Track 1+ model, which began in 2018. It is similar to the basic MSSP program, but it assigns beneficiaries prospectively at the beginning of the year. It differs from Track 1 in that it includes limited downside risk. In its first year, 55 ACOs agreed to participate in Track 1+.

What are ACOs accountable for?

Medicare ACOs are accountable for the total Medicare Part A and Part B spending for a defined population of beneficiaries and for the quality of their care.

Who can form an ACO?

ACOs are groups of providers such as physicians and hospitals. The group must include primary care providers because beneficiaries are assigned to ACOs based on their use of primary care services. Other providers such as specialists and hospitals can be included but are not required. Unlike MA plans, ACOs do not need to have a network that provides all Medicare services. This is because Medicare beneficiaries who are assigned to ACOs can, like any other fee-for-service (FFS) beneficiary, go to any provider who accepts Medicare. Beneficiaries are not “locked in” to the ACO.

Payment mechanics

Providers in ACOs generally continue to be paid their normal FFS rates by Medicare. In addition to these payments, ACO providers have the opportunity to

*This document does not
reflect proposed legislation
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earn bonus payments if, at the end of the year, actual total spending for the ACO's assigned beneficiaries is less than what spending for those beneficiaries was expected to be. An ACO that has chosen to enter a two-sided risk arrangement is also at risk of losses if actual total spending for its assigned beneficiaries is greater than expected.

When an ACO applies to the program, it specifies the providers in the ACO. Medicare then determines which beneficiaries received the plurality of their primary care from the providers in the ACO in the "baseline" time period.² Those beneficiaries are then assigned to the ACO.

To determine the expected spending of an ACO's assigned beneficiaries (the "benchmark"), CMS computes the total Part A and Part B spending for the ACO's assigned beneficiaries during the baseline period. In the MSSP program, the spending is averaged over the three-year baseline period, with more recent expenditures given more weight.³ To account for inflation, the baseline spending is trended forward using trends in FFS spending. At the end of the year, actual expenditures for the ACO's

assigned beneficiaries are compared with the spending benchmark, and savings or losses are computed. If there are savings (that is, actual expenditures are less than expected), those savings are shared between the Medicare program and the ACO at a defined shared savings rate. For example, in MSSP Track 1, ACOs can receive bonus payments of up to 50 percent of savings. If there are losses (that is, actual expenditures are greater than expected), those losses may be shared between the program and the ACO, if the ACO has chosen a two-sided risk arrangement. (Losses are not shared under a one-sided risk arrangement.) Ninety-one percent of MSSP ACOs have chosen to be in a one-sided risk arrangement. Quality also enters into the calculation of shared savings and losses. Essentially, the higher the quality, the greater share of the savings the ACO receives (and the smaller the share of the losses in a two-sided risk arrangement). In the MSSP, this process is repeated each year of the three-year contract, and then the ACO baseline is rebased to start another contract period.

In 2018, for the the MSSP program, the actual shared savings rates and other

Table 1 Parameters for the MSSP ACOs

Parameter	Track 1	Track 2	Track 3
Risk	One-sided	Two-sided	Two-sided
Minimum number of beneficiaries	5,000	5,000	5,000
Shared savings rate	50%	60%	75%
Performance payment limit	10%	15%	20%
Minimum savings rate (MSR)	Ranges from 2.0 to 3.9%*	Several options**	Several options**
ACOs in 2018	460	8	38
Shared loss rate	N/A	1 minus final shared savings rate***	1 minus final shared savings rate, but not less than 40%
Loss sharing limit	N/A	5% in year 1 7.5% in year 2 10% in year 3 and after	15%

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization).

*MSR varies inversely with assigned population, from 2.0% for an ACO with 60,000 or more beneficiaries to 3.9% for ACOs with 5,000 beneficiaries.

**Option 1: no MSR; Option 2: MSR ranges from 0.5 to 2.0%; Option 3: as in Track 1

***The final shared savings rate = shared savings rate × quality score.

Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2017. Medicare Shared Savings Program 2018 fast facts.

parameters can vary depending upon which of the three payment tracks an ACO chooses. Table 1 displays the options.

Over 90 percent of MSSP ACOs were in Track 1 in 2018 and thus were in one-sided risk arrangements with no risk of losses. Under current policy, ACOs are limited to two three-year agreement periods in Track 1. After that, they will have to transition to a two-sided risk arrangement, either Track 2 or Track 3, or to the Track 1+ model.

ACOs in the Next Generation demonstration have two-sided risk and can have shared savings rates up to 100 percent. ACOs in the Track 1+ model have a shared savings rate of 50 percent and a shared loss rate of 30 percent.

Risk adjustment— In determining the performance of ACOs in MSSP and NextGen, CMS takes into account the changing health status of an ACO's population. The MSSP differentiates between continuously assigned beneficiaries and newly assigned beneficiaries. The hierarchical condition category (HCC) risk scores of the newly assigned beneficiaries are assessed, and if their average is different from the average HCC score of the ACO's original population, the benchmark is adjusted (e.g., if the newly assigned beneficiaries' average risk score were higher than the historical population's risk score, the benchmark would be adjusted up). The average risk score of the continuously assigned population is also assessed. It can decrease or it can increase; however, it is only allowed to increase as much as a population with similar demographics.

Quality—CMS measures ACOs' quality in four domains:

- Patient/caregiver experience: 8 measures (16 possible points)
- Care coordination/patient safety: 10 measures (22 possible points; electronic health record measure is worth 4 points)
- Preventive health: 8 measures (16 possible points)
- Clinical care for at-risk population: 5 measures (8 possible points; the diabetes measure is a composite of 2 measures)

The total number of points earned in a domain is divided by the maximum possible number of points, generating a domain score. Each domain score is weighted at 25 percent of the total quality score. The total quality score is multiplied by the shared savings rate to find the final shared savings rate. That rate is used to determine the amount of shared savings the ACO receives if the ACO achieves shared savings. In two-sided risk models, the final shared loss rate is one minus the final shared savings rate (with some limits), which means the higher the quality score, the lower the shared loss rate.

Quality benchmarks are computed using Medicare claims data, data from the Physician Quality Reporting System (PQRS), quality data reported by ACOs, and quality data collected from the larger Medicare FFS population. ACOs can score additional points for significant quality improvement (in contrast to attaining specified levels of performance), up to four points in each domain. However, the total points earned cannot exceed the maximum number of points possible in the domain.

Results to date

CMS reports that the MSSP has shown modest success in improving quality, with MSSP ACOs showing improvement in performance on quality measures over time and achieving better results than FFS on many of the quality measures for which comparable results were available. CMS also reports that some ACOs have achieved modest reductions in spending relative to their benchmarks. The reductions to date have been disproportionately in ACOs in areas with high service use.

Table 2 summarizes the financial results for all three MSSP ACO tracks in 2017. For Track 1 ACOs, which are not at risk for any losses, the amount saved relative to the benchmarks was \$976 million, and \$686 million was paid to ACOs in shared savings payments. Once these payments are netted from the savings, Track 1 ACOs produced net savings of \$291 million overall (0.3 percent of benchmark). Track 2 and 3 ACOs, which share in losses, also produced

Table 2 Summary financial results of MSSP ACOs relative to benchmarks, by track, 2017

	One-sided model		Two-sided models			
	Track 1		Track 2		Track 3	
	Dollars (in millions)	Percent	Dollars (in millions)	Percent	Dollars (in millions)	Percent
Benchmark	\$85,424	100.0%	\$759	100.0%	\$8,732	100.0%
Actual Part A and Part B spending	<u>84,448</u>	<u>98.9</u>	<u>751</u>	<u>99.0</u>	<u>8,621</u>	<u>98.7</u>
Relative savings	976	1.1	8	1.0	111	1.3
Paid to ACO	-686	-0.8	-4	-0.6	-109	-1.3
Paid back to CMS	<u>0</u>	<u>0.0</u>	<u>2</u>	<u>0.3</u>	<u>16</u>	<u>0.2</u>
Net	291	0.3	5	0.7	18	0.2

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization). In 2017, the number of ACOs was 433 in Track 1, 6 in Track 2, and 33 in Track 3. "Relative savings" is defined as the difference between the benchmark and the actual spending. "Net" is the sum of relative savings and amounts paid to ACOs and paid back to CMS. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS MSSP ACO public use files.

net savings for the Medicare program. Relative to their benchmarks, Track 2 ACOs generated 0.7 percent in savings, and Track 3 ACOs generated 0.2 percent in savings.

As for the NextGen model, 2016 performance results, in Table 3, show that actual spending was less than the

aggregate benchmark, resulting in relative savings of \$48 million. After taking into account payments for shared savings and losses, there was a net relative savings of \$10 million. However, the benchmarks for NextGen ACOs are constructed with a built-in discount—an ACO-specific decrease in to the benchmark to ensure

Table 3 Summary financial results of Next Generation ACOs relative to benchmarks, 2016

	Dollars (in millions)	Percent
Benchmark	\$5,149	100.0%
Actual Part A and Part B spending	<u>5,101</u>	<u>99.1</u>
Relative savings	48	0.9
Paid to ACO	-58	-1.1
Paid back to CMS	<u>20</u>	<u>0.4</u>
Net	10	0.2
Discount	53	1.0
Total relative savings	63	1.2

Note: ACO (accountable care organization). There were 18 Next Generation (NextGen) ACOs in 2016. "Relative savings" is defined as the difference between the benchmark and the actual spending. Benchmarks for NextGen ACOs are constructed with a built-in discount—an ACO-specific decrease to the benchmark—to ensure savings for the program. "Net" is the sum of relative savings and amounts paid to ACOs and paid back to CMS.

Source: MedPAC analysis of CMS Next Generation ACO quality and financial results, performance year 1.

savings for the program. Taking into account the discount, the demonstration saved \$63 million relative to the benchmark.

It is important to note that when assessing the success of Medicare's ACO programs, the appropriate measure for expected Medicare spending should be used. Benchmarks are designed to reflect policy goals and create incentives for individual ACOs. Benchmarks do not necessarily represent the best counterfactual for an ACO program (i.e., what spending would have been in the absence of an ACO program). When assessing the success of a Medicare ACO program (such as

the MSSP) as a whole, a counterfactual measure should be used. Estimates of the counterfactual should take into account factors such as relevant trends in spending and the relationship between assignment and service use. ■

- 1 Medicare is beginning to allow beneficiaries to choose their "main doctor" and assign those beneficiaries to ACOs on that basis. Few have done so to date.
- 2 *Plurality of primary care* is defined as an ACO's practitioners providing the plurality of certain qualified evaluation and management services measured by charges for those services.
- 3 When resetting the benchmarks for subsequent three-year agreements, baseline years are weighted evenly, and regional expenditures will be factored in as well.

